STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING _____ B. WING _____	03/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NURSING CARE AT HARTSFIELD VILLAGE	503 OTIS R BOWEN DRIVE MUNSTER, IN46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 03/02/11 Facility Number: 010758 Provider Number: 155662 AIM Number: 200229550 Surveyor: Richard D. Schade, Life Safety Code Specialist At this Life Safety Code survey, Nursing Care at Hartsfield Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.	K0000	Preparation and / or execution of the plan of correction in general, or this corrective action in particular does not constitute an admission or agreement of Nursing Care at Hartsfield Village of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepaired and/or executed in compliance with State and Federal laws.It is the intention of this facility that this plan of correction serves as the facility's credible allegation of compliance with all regulatory compliance._____ _____ _____REVISED K 0054 AND K0067	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING _____ B. WING _____	03/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NURSING CARE AT HARTSFIELD VILLAGE	503 OTIS R BOWEN DRIVE MUNSTER, IN46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This two story facility with a partial basement was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, resident sleeping rooms and spaces open to the corridors. The facility has a capacity of 106 and had a census of 84 at the time of this survey. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 03/09/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING _____ B. WING _____	03/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NURSING CARE AT HARTSFIELD VILLAGE	503 OTIS R BOWEN DRIVE MUNSTER, IN46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0018 SS=E	Based on observation and interview, the facility failed to ensure 1 of 1 corridor doors to the employee break room would latch into the door frame or were provided with a device that exerts at least 5 pounds of pressure to keep the door tightly closed. This deficient practice could effect all occupants in and near the employee break room smoke compartment including staff, visitors and residents. Findings include: Based on observation on 03/02/11 at 11:45 a.m. with the maintenance supervisor, the corridor door to the employee break room was not equipped with a positive latching device that latched into the door frame or a device to provide at least five pounds of pressure to keep the door closed. The maintenance supervisor acknowledged at the time of observation, the door did not have positive latching device.	K0018	The employee break room door had a handset (positive latching device) installed on 3-8-11All resident, staff, and visitors near the employee break room had the potential to be affected by the deicient practice. Becouse the deficient door has been repaired, there is no more defective practice.The employee break room door will be inspected monthly during the "MONTHLY MAINTENANCE INSPECTION CHECKLIST FOR COMMON AREAS" form. It will be inspected to make sure that the employee break room door will close and latch into the door frame.The "MONTHLY MAINTENANCE INSPECTION CHECKLIST FOR COMMON AREAS" form will be brought to the Q.A. meeting for one year. Compliance will be reviewed during the meeting.	04/01/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING _____ B. WING _____	03/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NURSING CARE AT HARTSFIELD VILLAGE	503 OTIS R BOWEN DRIVE MUNSTER, IN46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(b)			
K0020 SS=E	Based on observation and interview, the facility failed to ensure 2 of 6 stair wells were enclosed with a construction rating of 1 hour fire resistance. This deficient practice affects all occupants on the second floor including residents, staff and visitors. Findings Include: Based on observations made between 12:25 p.m. and 1:15 p.m. on 03/02/11 with the maintenance supervisor, the stair well doors # 1 and # 2 from the second floor did not latch into the door frames when tested and did not maintain a fire resistance rating of one hour. The maintenance supervisor stated at the time of observation, he did not know why the stair well doors did	K0020	The #1 and #2 stair well doors from the secound floor were adjusted to close and latch into the frames. This was completed on 3-4-11.All residents, staff, and visitors had the potential to be affected by the deficient practice. The doors will be inspected monthly durring the "MONTHLY MAINTENANCE INSPECTION CHECKLIST FOR COMMON AREAS" form. The doors will be inspected to make sure they close and latch properly. The "MONTHLY MAINTENANCE INSPECTION CHECKLIST FOR COMMON AREAS" form will be brought to the Q.A. commetee quarterly for one year. Compliance will be reviewed during the meeting for tracking and trending.The #1, and #2 stair well doors from the secound floor were repaiared on 3-4-11.	04/01/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING _____ B. WING _____	03/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NURSING CARE AT HARTSFIELD VILLAGE	503 OTIS R BOWEN DRIVE MUNSTER, IN46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	not latch. 3.1-19(b)			
K0027 SS=E	Based on observation and interview, the facility failed to ensure 2 of 10 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect residents, staff and visitors in and near the smoke compartments of the B wing, first floor nurses station and the A wing, second floor. Findings include:	K0027	The smoke barrier doors for the 1st floor "B"-wing and the 2nd floor "A"-wing by the elevator were repaired on 3-4-11 by the maintenance department.The deficiency had the potential to affect all residents, staff, and visitors for the affected areas.The smoke barrier doors will be inspected monthly durring the "MONTHLY MAINTENANCE INSPECTION CHECKLIST FOR COMMON AREAS" forms. The smoke barrier doors will be checked to make sure the gap is no larger than 1/8 inch.The "MONTHLY MAINTENANCE INSPECTION CHECKLIST FOR COMMON AREAS" form will be brought to the Q.A. meeting quarterly for one year for tracking and trending.The smoke barrier doors for the 1st floor "B"-wing, and the 2nd floor "A"-wing by the elevator were repaired on 3-4-11.	04/01/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING _____ B. WING _____	03/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NURSING CARE AT HARTSFIELD VILLAGE	503 OTIS R BOWEN DRIVE MUNSTER, IN46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on observations with the maintenance supervisor between 11:15 p.m. and 3:00 p.m. on 03/02/11, the set of smoke barrier doors near the first floor nurses station on B wing had a 1/2 inch gap and the A wing set of smoke barrier doors on the second floor had a 1/2 inch gap near the bottom half of the doors when closed. At the times of observation. the maintenance supervisor acknowledged the gaps between the smoke barrier doors. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING _____ B. WING _____	03/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NURSING CARE AT HARTSFIELD VILLAGE	503 OTIS R BOWEN DRIVE MUNSTER, IN46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0029 SS=E	Based on observation and interview, the facility failed to ensure 2 of 6 soiled utility doors serving hazardous areas closed and latched to prevent the passage of smoke. This deficient practice could affect residents, visitors and staff in and near the hazardous areas. Findings include: Based on observations with the maintenance supervisor on 03/02/11 between 11:40 a.m. and 1:50 p.m., the doors to the hazardous rooms containing cleaning supplies and soiled laundry in the A wing first and second floor soiled utility storage rooms did not automatically close and latch. The storage rooms contained boxes, equipment, carts and laundry barrels. The maintenance supervisor acknowledged the problem areas at the time of observation.	K0029	The doors to the soild utility rooms for the 1A, and 2A units, have been adjusted to close and latch into the frames. This was completed by the maintenance department on 3-4-11.All the residents, staff, and visitors in the affected areas had the potential to be affected by the deficient practice.The soiled utility room doors will be checked monthly durring the "MONTHLY MAINTENANCE INSPECTION CHECKLIST FOR COMMON AREAS" forms. The soiled utility room doors will be checked to close and latch into the frames.The "MONTHLY MAINTENANCE INSPECTION CHECKLIST FOR COMMON AREAS" forms will be brought to the Q.A. commetee quarterly for one year for tracking and trending.The soiled utility room doors for the 1A, and 2A units were repaired on 3-4-11.	04/01/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING _____ B. WING _____	03/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NURSING CARE AT HARTSFIELD VILLAGE	503 OTIS R BOWEN DRIVE MUNSTER, IN46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING _____ B. WING _____	03/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NURSING CARE AT HARTSFIELD VILLAGE	503 OTIS R BOWEN DRIVE MUNSTER, IN46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0051 SS=D	Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm pull stations in the basement corridor near the elevator was readily available. LSC 9.6.2.6 requires a manual pull station to be unobstructed and accessible. This deficient practice affects all staff in the facility's basement. Findings include: Based on observation on 03/02/11 at 3:45 p.m. during a tour with the maintenance supervisor, the fire alarm pull station located in the basement near the elevator was blocked from access by 53 stacking chairs, eight desk drawers and a folding table. The maintenance supervisor acknowledged at the time of observation, the pull station was obstructed and not accessible. 3.1-19(b)	K0051	The items that were blocking the access to the fire alarm pull station were removed on 3-7-11 by the maintenance department.This deficiency had the potential to affect all staff in the basement area. The basement area is not a resident area. The items were removed on 3-7-11, and no other items will be stored in this area.A sign will be placed on the wall of the affected area that will read "NO ITEMS ARE TO STORED IN THIS AREA". All current employees that have responsibilities in the basement will be educated on the need to keep this area clear. The maintenance director will monitor the area for compliance Monday through Friday and sign a compliance sheet for sixty days. The compliance sheet will be located on the wall of the affected area.The compliance report will be brought to the Q.A.committee quarterly for one year for tracking and trending.The area has been cleared of the items that were blocking the fire alarm pull station on 3-7-11. The compliance conformation sheet was posted on 3-17-11.	04/01/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING _____ B. WING _____	03/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NURSING CARE AT HARTSFIELD VILLAGE	503 OTIS R BOWEN DRIVE MUNSTER, IN46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0054 SS=E	Based on observation and interview, the facility failed to ensure 6 of 188 smoke detectors in the facility were installed where air flow would not adversely affect their operation. LSC 9.6.1.3 says the provisions of 9.6 cover the basic functions of a complete fire alarm system. Section 9.6.1.4 requires fire alarm systems comply with NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could effect residents in and near each of the corridor smoke detectors, including staff and visitors. Findings include: Based on observations with the maintenance supervisor on 03/02/11 between 11:15 a.m. and 3:00 p.m., the smoke detectors in the corridors near resident rooms	K0054	Because of the time that has elapsed from the original survey date, the April 1, 2011 deadline is not feasible. The vender is scheduled to begin moving the affected smoke detectors on April 1, 2011, and the job completed by April 8, 2011.The hall smoke detectors near the resident rooms B202, D201, C102, C108, B102, and the A-wing first floor living room will be moved so the air flow will not affect the operation of the smoke detectors.All of the facility halls and lounge areas were inspected on March 10, 2011 for the placement of the smoke detectors. All the smoke detectors in the halls and lounge areas will be located so the air flow will not prevent operation of the smoke detectors.The vender is scheduled to begin moving the affected smoke detectors on April 1, 2011.The job will be completeed by April 8, 2011.	04/08/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING _____ B. WING _____	03/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NURSING CARE AT HARTSFIELD VILLAGE	503 OTIS R BOWEN DRIVE MUNSTER, IN46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	B202, D201, C102, C108, B102 and the A wing first floor living room were located within two feet of an air supply duct. This was acknowledged by the maintenance supervisor at the time of the observation. 3.19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING _____ B. WING _____	03/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NURSING CARE AT HARTSFIELD VILLAGE	503 OTIS R BOWEN DRIVE MUNSTER, IN46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0056 SS=E	Based on observation and interview, the facility failed to ensure 2 of 8 sprinkler gauges were tested every five years. NFPA 25, Section 2-3.2 states gauges shall be replaced every five years or tested every five years by comparison with a calibrated gauge. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation with the maintenance supervisor on 03/02/11 between 11:25 a.m. and 3:00 p.m., the sprinkler gauge in the # 4 stairwell on D wing, second floor had no observable date on the gauge to show when it had been replaced or recalibrated. The D wing first floor stairwell sprinkler gauge was dated 1997. The maintenance supervisor stated at the time of observation, he did not realize the sprinkler gauges had not been inspected or recalibrated.	K0056	The sprinkler gauges for the #4 stair well on the second floor, and the #4 stair well on the first floor were replaced by McDaniel Fire Systems on 3-8-11. It was also determined that another gauge in the basement fire pump room needed replaced. This was also corrected on 3-8-11 by McDaniel Fire Systems. All of the sprinkler guages have the date they were replaced written on the face.All residents, staff, and visitors, in the facility had the potential to be affected by the deficiency. McDaniel Fire Systems will be reminded of the requirement that the sprinkler gauges be replaced every five years. And that this is addressed on the documents submitted for the quarterly testing. The facility maintenance director will review the quarterly documents for the sprinkler testing and confirm that the sprinkler system gauges were checked. Reports of compliance will be brought to the Q.A. committee quarterly for tracking and trending.The guages for the sprinkler system were replaced on 3-8-11.	04/01/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING _____ B. WING _____	03/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NURSING CARE AT HARTSFIELD VILLAGE	503 OTIS R BOWEN DRIVE MUNSTER, IN46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(b)			
K0062 SS=E	Based on observation and interview, the facility failed to ensure a clearance of at least 18 inches was maintained from the sprinkler deflector for 2 of 2 sprinklers in the kitchen freezer and cooler. NFPA 25, 2-2.1.2 requires unacceptable obstructions to spray patterns shall be corrected. Further NFPA 13, 1999 edition, at 5-5.5.1 says a continuous or noncontinuous obstruction less than or equal to 18 inches from the sprinkler deflector prevents the spray pattern from fully developing. This deficient practice affects staff in and near the the kitchen freezer and cooler. Finding include: Based on observations made at 2:25 p.m. on 03/02/11 during a tour with the maintenance supervisor, the sprinkler heads in the kitchen	K0062	The light fixtures in the kitchen freezer and cooler were relocated and are no longer obstructing the sprinkler heads. This was completed by an outside vender on 3-4-11.The freezer and cooler are located inside the kitchen and this is not a resident or visitor area. Only staff had the potential to be affected by the deficient practice. The deficient practice was corrected on 3-4-11.The light fixtures are securely mounted to the ceilings of the freezer and cooler. There are no systemic changes needed to ensure the deficient practice may recur.The corrective action will not have the need to be monitored. The light fixtures are securely mounted to the ceilings of the freezer and cooler, and can not be moved by accident.	04/01/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING _____ B. WING _____	03/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NURSING CARE AT HARTSFIELD VILLAGE	503 OTIS R BOWEN DRIVE MUNSTER, IN46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	freezer and cooler were obstructed by the light fixture in each storage area. The maintenance supervisor stated at the time of observations, they were not aware of the problem. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING _____ B. WING _____	03/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NURSING CARE AT HARTSFIELD VILLAGE	503 OTIS R BOWEN DRIVE MUNSTER, IN46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0067 SS=F	Based on record review and interview, the facility failed to ensure 24 of 24 dampers in the ductwork at smoke barriers were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review with the maintenance supervisor on	K0067	Because of the amount of time and work needed to correct the deficiency, we feel we will not be able to have the deficiency corrected by April 1, 2011. Therefore we are submitting a time table with targeted dates, and a completion date for the fire damper inspections.a) Contact vender to locate and access all fire dampers.b) Inspect and exercise all accessable fire dampers.c) Document all fire dampers that need more accessability to complete the inspection. Items labled a,b,and c, have a target date of April 11, 2011.d) Determine the venders needed to make the unaccessable dampers accessable. (Construction, HVAC, ect.)e) Aquire quote for vender.f) Request funds for project.Items labeled d,e, and f have a target date of April 29, 2011.g) Order supplies needed for the project.h) Receive supplies and schedule project. i) Complete project by May 30, 2011.	05/30/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING _____ B. WING _____	03/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NURSING CARE AT HARTSFIELD VILLAGE	503 OTIS R BOWEN DRIVE MUNSTER, IN46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	03/02/11 at 10:35 a.m., there was no evidence all 24 dampers in the ductwork had been inspected since 12/20/06. Based on an interview with the maintenance supervisor at the time of record review, he was unable to provide evidence the dampers had received a current and complete inspection and the required maintenance. The maintenance supervisor stated he had verified the lack of a current inspection with Tyco-Simplex, the inspection company. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING _____ B. WING _____	03/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NURSING CARE AT HARTSFIELD VILLAGE	503 OTIS R BOWEN DRIVE MUNSTER, IN46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0144 SS=F	Based on observation, record review and interview; the facility failed to ensure 1 of 1 emergency generators was equipped with remote manual stops. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for the shutting down the engine at the engine and from a remote location. This deficient practice could affect all residents,	K0144	The vender was contacted for a quote to have the remote shut off installed for the generator. The project is scheduled for March 22, 2011.This deficiency has the potential to affect all residents, staff, and visitors in the event of an emergency. The remote shut off is scheduled for installation on 3-22-2011. When the remote shut off is installed on 3-22-11. It will be monitored by the generator panel. The panel will alarm if the "stop switch" or the "remote stop switch" is not in the normal position.The generator remote enunciator pannel is located at the first floor nurses station.	04/01/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING _____ B. WING _____	03/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NURSING CARE AT HARTSFIELD VILLAGE	503 OTIS R BOWEN DRIVE MUNSTER, IN46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	staff and visitors in the event of an emergency. Findings include: Based on review of the Generator Maintenance records on 03/02/11 at 10:20 a.m. with the maintenance supervisor, there was no documentation available which indicated the amount of horsepower the generator motor provided. Based on observation of generator equipment on 03/02/11 at 3:15 p.m. during a tour of the facility with the maintenance supervisor, no evidence of a remote shut off device was found for the generator, furthermore, the maintenance supervisor indicated he was not sure if the generator was 100 horsepower or more. The maintenance supervisor indicated he was not aware of a remote shut off device for the generator and thought the generator was installed before 2003.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING _____ B. WING _____	03/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NURSING CARE AT HARTSFIELD VILLAGE	503 OTIS R BOWEN DRIVE MUNSTER, IN46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(b)			